State Board of Medical Examiners
Department of Law and Public Safety
Division of Consumer Affairs
140 E. Front Street
Trenton, N.J. 08608

STATE BOARD OF MEDICAL EXAMINERS

Issue 28 **NEWSLETTER** **Spring 1998**

Bernard Robins, M.D.
President
State Board of Medical Examiners

Statement from the President
Bernard Robins, M.D.

The following speech was given by Dr. Bernard Robins to the Board of Medical Examiners in acceptance of the position of Board President. The session took place at the Richard J.Hughes Justice Complex in Trenton on July 9, 1997.

I wish to take this opportunity to thank the members of the Board for allowing me to serve in this office. I can assure you that I shall make every diligent effort to carry out my responsibilities in the best possible fashion, and thereby earn what you have already given me in advance — your confidence and trust. I would like to spend a few moments letting you know who I think we are and where we are going.

Whereas in the past, the Board of Medical Examiners was considered to be an adversarial body by its licensees, we have, under the leadership of Board Presidents Luka, Malta, Grossman, Lewis, Jacobs and Johnson moved to a more compassionate and egalitarian position which has brought us to enjoy the respect of our licensees. It is an honor to be able to join the ranks of my predecessors and help lead this Board into the next phase of its critical societal and governmental role. Our challenge is ever more complex - to appropriately face the changed world in which health care has become managed care.

What are our resources and their limits? They are a highly competent administrative staff, but also a severely shorthanded and overworked one. They work without the necessary electronic tools of the communications age. We must vigorously support the efforts to make their work more modern and efficient. Also, we have a fine legal support system with excellent, devoted attorneys who lead us through the morass of legal conundrums, but who are also short staffed and spread too thinly.

The Board itself is quite new, the mean longevity of its members being less than two years. This unfortunately leaves us without institutional memory and with the great need for rapid education. We must also take on more individual responsibility.

(continued on page 6)

Inside...

Duty To Cooperate And Comply With Board Orders

The Division of Consumer Affairs has adopted uniform regulations requiring all licensees of the professional boards to cooperate in any inquiry, inspection or investigation conducted by or on behalf of the Board. A licensee's failure to cooperate may constitute unprofessional conduct, and thus the licensee may be subject to disciplinary action.

The following actions may be deemed a failure to cooperate:

- Failure to respond in a timely manner to an inquiry for information.
- Failure to provide records related to licensee conduct in a timely manner.
- Failure to attend any scheduled proceeding at which the licensee's appearance is directed.
- Failure to provide information in a timely manner pursuant to a request.
- Failure to provide access to premises from which a licensed profession is conducted.
- Failure to answer any question.
- Failure to respond to a subpoena.
- Failure to notify the Board in a timely manner of a change of address.
- Failure to comply with any order duly entered by the Board.

State Board of Medical Examiners

Issue 28 **Spring 1998**

THE NEWSLETTER provides pertinent information but is no substitute for statutes, regulations, and legal actions. It is published for professionals licensed by the Board. Inquiries, address changes and other correspondence should be sent to: *Department of Law and Public Safety, Division of Consumer Affairs, State Board of Medical Examiners, 140 East Front Street, 2nd Floor, Trenton, New Jersey 08608 (609)826-7100.*

Practicing Acupuncture?

Regulations adopted by the Board, through the Acupuncture Examining Board, require specific training in order for physicians to practice acupuncture. Those requirements shall consist of a course of training of at least 300 hours, including at least 150 hours in clinical training, in order to be credentialed to practice acupuncture. The Acupuncture Examining Board will review all relevant course work and issue a certificate attesting to the completion of the required training.

In order to be considered a "licensed acupuncturist," physicians may apply to the Acupuncture Examining Board. Applicants would be required to successfully complete the National Commission for the Certification of Acupuncturists and Oriental Medicine Examination (formerly NCCA) as well as the New Jersey Oral-Practical Examination in order to obtain a license. Contact the Board office for details at 609-826-7100.

Physician Assistant Scope of Practice Defined

The physician assistant is a dependent practitioner and may only function within the scope of practice of the supervising physician. During 1996, the Board of Medical Examiners adopted regulations defining the scope of practice of a licensed physician assistant (PA). Within that scope of practice, the licensed PA may perform the following procedures on a discretionary and routine basis:

- performing physicals and recording medical histories;
- suturing and follow-up care of wounds;
- providing patient counselling services;
- assisting a physician in inpatient and outpatient settings;
- collecting fluids for diagnostic purposes;
- placing and utilizing access catheters and tubes for diagnostic, therapeutic or interventional purposes;
- performing minor surgical procedures, and applying and removing medical and surgical appliances;
- managing emergency and life threatening conditions.

In addition, the PA may perform low-risk obstetrical deliveries in a licensed hospital with the supervising physician or physician designee on premises and available to respond immediately.

Other procedures may be performed provided they are within the training and experience of both the supervising physician and the physician assistant. The procedures may only be performed by the PA at the direction, order or prescription of the physician.

These procedures include:

- performing or assisting licensed personnel in non-invasive laboratory procedures and related studies;
- giving injections and administering medications and ordering diagnostic studies; and
- suturing and caring for facial wounds, traumatic wounds requiring suturing in layers and infected wounds;
- in an inpatient setting only, order medications and prescribe only prescription legend drugs other than controlled dangerous substances;
- writing orders to implement therapeutic plans developed jointly with the supervising physician.

Providing the PA has been credentialed to perform such a function, the PA may also act as a first assistant in surgery under Board regulations governing major surgical procedures. (See related article on Assistants in Surgery.)

Finally, the Board has established credentialing guidelines for the supervising physician to document the competency of the physician assistant to perform other procedures. A supervising physician is responsible to assess and document the PA's training, experience and proficiency for these procedures. The PA may perform procedures which would include the introduction of contrast materials for diagnostic, therapeutic or interventional purposes such as radiological studies; the use of an endoscopic instrument; the aspiration of fluids from joints and body cavities; the collection of cerebrospinal fluid; the biopsy of tissues, and the placement of central venous catheters or chest tubes and endotracheal intubation.

The regulations and the credentialing guidelines are available from the Board office.

Board Adopts Regulations For In-Office Surgery And Anesthesia

In an effort to provide a high standard of care and assure patient safety, the Board of Medical Examiners has adopted a series of standards to regulate the performance of surgery and the administration of anesthesia in an office setting. The standards specifically delineate safety standards for operating and recovery rooms.

In recent years, the Board took notice of the fact that more and more procedures were being performed in the office setting. It recognizes that there are clear-cut benefits to this trend in terms of lowered cost and shorter and more comfortable recuperation periods. Many offices in New Jersey provide state-of-the-art technology and are fully equipped to offer the services to patients. However, other offices have not been so equipped and instances of physicians delegating the performance of vital monitoring requirements to unlicensed or inadequately trained personnel have come to the attention of the Board. In response to those concerns, the Board chartered a task force to evaluate the need for regulation in this area. The task force represented a broad range of physician interest and specialty organizations. After reviewing the recommendations made by the task force, the Board has determined that patients deserve an equivalent standard of care and safety regardless of the site of their surgical procedure. Over the last several years, Board members, staff and task force members reviewed various draft proposals, as well as regulatory provisions adopted by the Department of Health and Senior Services relating to the administration of anesthesia in the hospital and ambulatory surgery facility. In addition, the task force considered guidelines promulgated by various professional societies and reviewed relevant articles appearing in medical literature.

Like the regulations of the Department of Health and Senior Services, the regulations prescribe certain monitoring requirements linked to the level of anesthesia which is to be provided. Throughout the regulation there is a recognition that certain personnel need to have been trained in Advanced Cardiac Life Support. Anesthesia services are defined to include general and regional anesthesia as well as conscious sedation. Excluded from the definition are topical or local anesthesia, minor conduction blocks and pain management or pain medication. Expressly excluded from the definition of conscious sedation is a minimal pre- procedure dose of tranquilizer. Standards for the administration of each form of anesthesia are set forth, including pre- procedure counseling and screening, preparation of surgical and anesthesia records, safety systems and monitoring requirements. Also included are requirements for adequate recovery areas and personnel.

The Board will also establish an alternate process to credential those physicians who do not hold privileges to administer anesthesia or to perform surgery in a licensed hospital to allow them to perform those procedures in their offices. The alternate credentialing process will be described in a later proposal.

The regulations were published in The New Jersey Register in May 1997 and a public hearing on the issue was conducted on June 4, 1997. The Board adopted the regulations at its December 10, 1997 meeting. The new regulations become effective upon publication in the New Jersey Register.

Physicians Required To Report Toy-Related Injuries

State law and regulation requires physicians to report any injury or death of a person of any age where there is reason to suspect that it may be toy related. Under the Regulation, NJAC 13:45A-24.2, enforced by the Division of Consumer Affairs, a physician is required to file an initial report no later than the next business day, to be followed by a written incident report.

Initial reports should be made by telephone during business hours (8:30 - 4:30, Monday - Friday) to 973-504-6257. Completed written forms, provided by the Office of Consumer Protection, should be sent to the following address:

Executive Director, Office of Consumer Protection
Division of Consumer Affairs
P.O. Box 45025
124 Halsey Street
Newark, New Jersey 07101

Ultimately, the reports are made available to the United States Consumer Product Safety Commission.

Alternative Resolution Program For Impaired Physicians

July 1997 marked the end of a two-year trial period for regulations that established an alternative pathway for licensees suffering from the diseases of impairment as a result of chemical or alcohol dependency. The regulations establish procedures for the Board to enter into relationships with recognized professional treatment programs. After the adoption of the regulations in July 1995, the Board entered into an agreement with the Physicians Health Program ("PHP") of the Medical Society of New Jersey, whereby the PHP conducts an inquiry under strict confidentiality to ascertain the nature and extent of the impairment and establishes an agreement and plan for the rehabilitation and treatment of the licensee.

The regulation also establishes an intermediary committee, known as the Impairment Review Committee ("IRC") to accept coded confidential reports from the PHP on a monthly basis, which contain sufficient information for the IRC to conduct a meaningful review. The IRC, comprised of two Board members, two representatives of a professional assistance program and a representative of the Department of Health and Senior Services, may then determine if confidential participation in the PHP is appropriate, or if the physician's continued practice may pose an imminent danger to patients thus making a referral to the Board appropriate. Participation in the program requires the licensee to sign an agreement for treatment and/or monitoring. Failure to adhere to treatment plans or other evidence of a relapse are grounds for a report to the Board of Medical Examiners.

Under New Jersey law, physicians are required to report colleagues who may be suffering from impairment. The new regulations provide that this reporting requirement can be satisfied by reporting an individual directly to the IRC or the PHP.

Assistants In Major Surgery

The Board of Medical Examiners has recently modified its regulation on major surgery (N.J.A.C. 13:35–4.1) to identify which individuals may act as a qualified first assistant. The use of a qualified first assistant is required when a major surgical procedure is performed. A "major surgical procedure" is defined as one "which poses a substantial hazard to the life, health or welfare of a patient." By way of example, such a procedure includes a method where an opening is made into any of the three major body cavities (abdomen, chest or head), exclusive of endoscopic approaches which explore existing body channels, or diagnostic procedures such as laparoscopy or colposcopy. A qualified first assistant must be immediately available in the operating suite during a diagnostic endoscopic procedure requiring the traversing of a body wall. Major surgical procedures also include major amputations or procedures where the locality, condition, difficulty or length of time required to operate would constitute a direct hazard to the life of the patient.

A qualified first assistant was previously defined to be a physician or a resident rotating through a training program approved by the Accreditation Council on Graduate Medical Education or the American Osteopathic Association. The latest revisions approved by the Board now permit a duly-qualified registered nurse first assistant (RNFA) or duly-qualified physician assistant (PA) to act in this capacity. Medical staffs are required to develop appropriate rules to implement these regulatory requirements and to determine which procedures are to be deemed major surgical procedures. In addition, the medical staff shall determine the appropriate credentials for each individual qualified to act as a first assistant for any given surgical procedure. Although the regulation permits the use of RN first assistants (RNFA) or PAs, the operating surgeon has the discretion to determine whether to utilize such an individual.

In the event of the incapacity or unavailability of the operating surgeon, a PA or RNFA is limited to maintaining the status of the patient until a replacement surgeon can be summoned, unless a dire emergency poses a risk of imminent death to the patient or if serious bodily injury occurs.

Governor Signs Law Aimed At Prescription Fraud And Abuse

Citing examples of millions of dollars in prescription fraud, Governor Christine Todd Whitman signed legislation that requires the use of non erasable, non reproducible prescription blanks in the State of New Jersey. The law requires that all prescriptions written in New Jersey shall be issued on uniform New Jersey Prescription Blanks (NJPBs) subject to stringent security controls, in order to deter prescription drug abuse and prescription forgery. The operative date of the new act was December 1, 1997. For ninety (90) days following the operative date, pharmacists may accept prescriptions which are not written on NJPBs but only if the pharmacist verifies the prescription with the prescriber or health care facility. Under the statute, pharmacists in New Jersey may not accept a prescription from a New Jersey prescriber unless it is presented on a state-approved form.

The Division of Consumer Affairs, through the Office of Drug Control, has developed specifications for the production of NJPBs and has compiled an approved list of vendors for the prescription blanks. NJPBs may be purchased only from one of these approved vendors. The NJPBs will be made available in three forms:

(1) single forms;

(2) two-part carbonless forms; and

(3) computer-ready forms capable of being fed into a computer printer.

NJPBs can only be printed using the official name on file with the Division of Consumer Affairs and can only be delivered to the official address on file with the Division of Consumer Affairs. At the option of the prescriber or health care facility, the NJPBs may be pre printed with more than one prescriber's name, multiple office locations, consecutive numbers (serialized), the medication ordered, and/or a bar code which identifies the medication prescribed.

Speech

continued from page 1

Our recent achievements have been significant. We have instituted the Alternative Resolution Program which is successfully rehabilitating but not punishing impaired physicians. The good offices and expertise of the Physicians Health Program of the Medical Society of New Jersey have been vital to the Alternative Resolution Program. We have promulgated regulations concerning sexual misconduct, proposed new surgical and anesthesia standards and are moving to amend corporate and professional practice rules. We have developed guidelines for managed care medical directors. We are liberalizing the use of C.D.S. for the treatment of chronic pain.

What are our immediate tasks? We must continue to streamline and improve our licensure processes, including using the Federation of Medical Boards' document verification service. We are also undertaking a review of the licensing requirements and we shall be making regulatory and suggesting statutory changes to modernize the process, making it unambiguous, while maintaining high standards. We are starting the process of looking at telemedicine - again a major regulatory effort. We are developing a Focused Reeducation Program so that we can salvage the practitioner whose skills have diminished and would otherwise be lost as a community asset. We are developing a data base of experts to help us in areas where our own knowledge is insufficient to be able to judge the medical care given. We are continuing to be involved in the budgetary process through our budget committee so that our licensees can be assured that their licensee fees are most efficiently and appropriately used. We have a mechanism in place so that we can investigate inappropriate and adverse decisions of managed care medical directors while working closely with the Department of Health and Senior Services and the Department of Banking and Insurance.

Surely, a major thrust of our disciplinary efforts will be directed towards the elimination of the abuses that are occurring in the area of insurance fraud. Again, we have established cooperative mechanisms with other branches of state government and with the private sector.

All in all, we have many challenges in front of us. We must educate ourselves; we must support our staff; we must maintain the honor and the dignity of the profession, our licensees, and this Board. We must lead by example. We must be evenhanded and consistent in our judgments. We must be humble as we use our power, and compassionate in our dealings with our charges. We must remember that our role is to protect the public. We must discipline the miscreant and rehabilitate the salvageable. All must be accomplished with a sense of obligation and service.

I have asked you for your help in these large tasks — I also pledge to you that I will work as hard as I can to help you achieve these goals.

Thank you.

Board Announces Findings Of Managed Care Hearing

With the rapid growth of managed care entities in the State of New Jersey, questions have arisen as to whether the structure and rules of those entities may adversely affect the welfare of patients. In response to questions directed to the Board by the public and its licensees, the Board conducted a series of public hearings in early 1996 to determine if a patient's quality of care can be affected by contractual relationships which provide financial incentives to limit referrals,or deny emergency room visits or care. In addition, the Board reviewed information on so-called "gag clauses" which prohibit physicians from disclosing details of their contractual relationships or deprive patients of the opportunity to make appropriate decisions concerning their treatment.

In three days of hearings conducted across the state, the Board heard from over 60 individuals and organizations, including 27 practicing physicians and 17 physician organizations. Significant testimony was also heard from the public at large and various union and consumer organizations.

In its recommendations, the Board recognized the physician-patient relationship as a fundamental precept of medical practice and expressed concern regarding managed care plans that prevent review of all possible treatment options with a patient. The Board views any contractual provision which limits the disclosure and discussion of any treatment options to be inimical to the physician-patient relationship. The failure to disclose information and review all possible treatment options — even those that the managed care plan may not cover, engenders mistrust and fear in the physician-patient relationship.

The Board has also recognized that several entities of state and federal government have some jurisdiction over the various forms of managed care. As such, the Board has suggested that some informal means of coordinating policy on the state government level be established.

The Board considered establishing regulations that would prohibit a physician from entering into a contract that contained financial incentives to limit treatment or referral. Rather than pursuing an outright prohibition, the Board expressed confidence in its investigative function to address these issues on a case-by-case basis. Nevertheless, the Board has found that such financial arrangements are contrary to the best interests of patient care. The Board expects its licensees to deliver an appropriate standard of care regardless of the reimbursement arrangement.

As an outgrowth of the Board's report, a "Managed Care Committee" has been established to review complaints from patients and practitioners, as well as to coordinate policy matters with the various other sections of state government involved in the regulation of these entities.

In addition, the Board is in the process of developing guidelines for managed care medical directors, consistent with the Department of Health and Senior Services' HMO regulations, as well as the provisions of the Health Care Quality Act, signed by Governor Whitman in June 1997.

For a full copy of the Board's Managed Care Report, contact the Board office.

The Anatomy Of Insurance Fraud

By Mark S. Herr
Director
Division of Consumer Affairs

Billions of dollars are taken from consumers each year and most do not even know that it is happening. It is sometimes thought of as a "victimless" crime since it does not involve guns, ski masks or knives. But health insurance fraud costs Americans billions of dollars - losses that are translated into higher premiums that all of us must pay. That makes all of us victims of health insurance fraud.

In 1996, Governor Christine Whitman's Health Care Fraud Task Force, led by Attorney General Peter Verniero, estimated that health care fraud costs New Jerseyans approximately $3.5 billion annually, almost 18% of the national figure of $20 billion. Of every insurance premium paid in New Jersey, New Jerseyans pay $200 dollars in additional premiums to cover losses attributed to health insurance fraud. The insurance company, the policyholder, the taxpayer and the general public all ultimately subsidize the cost of insurance fraud.

This fraud is not limited to cases involving private insurers. The dishonest also take aim at Medicare and Medicaid and some state health coverage programs. When these men and women pillage these programs, taxpayers are defrauded again.

Why does this happen? Greed. Greed prompts some medical professionals to falsify diagnostic codes in order to be paid by the insurers for noncovered treatments. Greed causes others to invent patients and stage accidents. The more medical tests, treatments and supplies provided to patients, the larger the profit margin for medical providers.

Too many wrongdoers are helped by unscrupulous attorneys. The results are excessively high bills or unwarranted medical bills. Higher bills mean higher payouts.

Unnecessarily high payouts mean unnecessarily high premiums.

It is also not hard to recognize the incentive for individuals who seek to take advantage of the insurance industry. There exists too great a potential for significant monetary recoveries for the unscrupulous when they engage in insurance fraud by fabricating the nature of the injury suffered, by falsely claiming to be a passenger in an accident or by "staging" accidents. The accident "victim" who seeks to enhance his or her injury uses the health care practitioner to maximize his bill. The fraudulent providers' profits come from the high volume of such cases. In some cases, the professionals actively solicit persons involved in auto accidents and willingly participate in the fraud in order to reap financial benefits. However appalling this fact may be, it is not surprising that some medical providers devote virtually all of their practice to auto accident victims who are seeking relatively moderate recoveries. Fraud cases can prove to be a windfall for all except the consumers who end up paying higher insurance premiums to cover the fraud losses.

Four years ago, the Division of Consumer Affairs made a commitment to fight this growing problem. The result has been a 33 percent jump in investigations and prosecutions, and increases in the number of revoked licenses and penalties imposed. During the coming months, Consumer Affairs, the Division of Criminal Justice and the Department of Banking and Insurance will be working more closely than ever before to increase the number of civil and criminal fraud prosecutions.

The Division of Consumer Affairs' Board of Medical Examiners ("BME") has a crucial role to play in this effort. Those who abuse their licenses and use them as a license to steal must be disciplined to the fullest extent of the law. Once those who commit fraud are identified, an investigation will be conducted and they will then be prosecuted if found to have committed fraud.

Last year's case against an East Orange doctor illustrates the nature of the cases. After investigating, the Division of Consumer Affairs and the BME filed a 387-count complaint against Dr. Henry Miles Sherman. As a result, the BME revoked Sherman's license, effective May 10, 1996. Federal authorities successfully prosecuted him in U.S. District Court, and he was convicted on criminal charges of having committed mail fraud. Sherman is now serving a 30-month jail sentence. Dr. Sherman admitted that he defrauded insurance companies by submitting bills for treatments and equipment that were not actually provided to his patients. He was ordered to reimburse investigative costs and make restitution to the insurers.

Sherman was not alone. On May 6, 1997, in another case of fraud, the BME ordered an orthopedic surgeon, Dr. Dan W. Parkinson, to pay $100,000 and suspended his license for five years. The complaint alleged that Parkinson submitted claims for the completion of "complex orthopedic evaluations" on 222 patients in one day alone. The patients, who were allegedly injured in auto accidents, were each seen for approximately 1 to 5 minutes. The insurance company was billed $45,265 for that single day of work. Dr. Parkinson has appealed the BME's ruling. Other charges against Parkinson are still pending.

In a third case, the BME revoked the license of Dr. Lawrence Nessman, of Passaic County, on March 6, 1997, and ordered him to pay $93,443. A Consumer Affairs investigation found evidence that Nessman had attempted to defraud insurance companies. Dr. Nessman submitted false medical reports for patients, most of whom were "victims" of auto accidents. In numerous instances, Nessman billed insurance companies for medical services to patients in New Jersey on dates when airline records indicated that he was out of state and no physician was covering his practice.

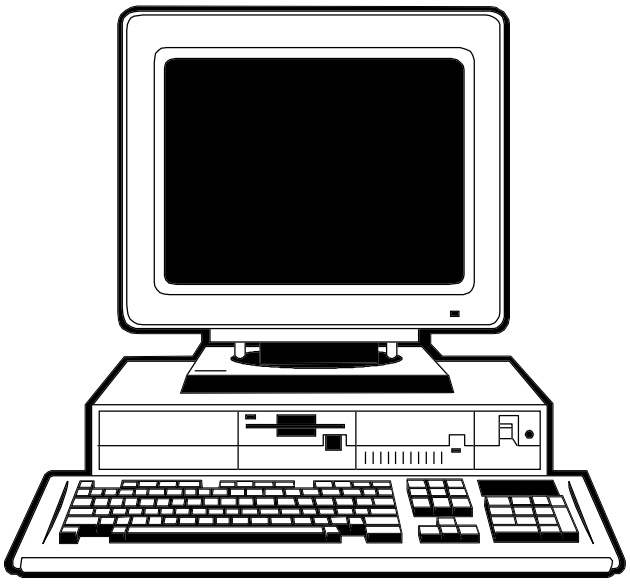
Medical practitioners deserve to be considered among our most trusted professionals. It is unfortunate that a few unscrupulous professionals and patients threaten the quality of health care and make it necessary for all to be skeptical and guarded.

Governor Whitman, Attorney General Verniero and I have made fighting health insurance fraud in the coming year one of their top priorities. To the insurance industry, insurance fraud is a major destructive force. To the consumer, insurance fraud could potentially lead to even higher costs to cover the greed of the unscrupulous. New Jersey will not tolerate insurance fraud.

Task Forces Formed on Bariatric Practice, Telemedicine

In the wake of the controversy surrounding the use of medications such a "Phen-Fen" and Redux for weight control, the Board of Medical Examiners formed a task force to develop guidelines and recommend regulations defining the appropriate treatment of patients. The Task Force will research and explore requirements for conducting and documenting appropriate physical examinations, laboratory and diagnostic studies. Task Force recommendations are expected to be considered by the Board of Medical Examiners in early spring.

Director of Consumer Affairs Mark S. Herr has assembled an extensive Task Force to study the issue of telemedicine and licensure. This form of medical practice and related technology is expanding. The Task Force has been asked to research issues involving privacy, quality of care, technology and licensure and to devise a reasonable means to control such practice and provide adequate protection to New Jersey health care consumers. The Task Force has been asked to craft suggested legislation to deal with this issue. Telemedicine Task Force recommendations are also expected in early spring.



State of New Jersey
Department of Health And Senior Services
CN360
TRENTON, N.J. 08625-0360

Dear Physician:

I am writing to inform you that the New Jersey Department of Health and Senior Services recently adopted new regulations governing the operation of HMOs in this state. These regulations provide some of the strongest consumer protections available to HMO members anywhere in the country.

HMOs are required to inform members of their rights under these regulations and I also want to ensure that every physician practicing in New Jersey is familiar with these rights. I appreciate the opportunity presented by the Board of Medical Examiners to bring this message to you.

I have attached a copy of these rights and encourage you to review them. One of the guiding principles in developing the regulations was to protect the rights of patients by providing physicians with greater freedom to act on behalf of their patients.

I want to highlight a few examples of protections that I believe will be of particular interest to you. The regulations preclude HMOs from including "gag clauses" in physician contracts thereby enabling physicians to discuss all medical treatment options, even if they are not covered services. The regulations provide an independent appeals process established for members and physicians acting on behalf of members who want to appeal decisions by the HMO to deny or limit coverage. This process is available for members and physicians who are dissatisfied with the results of an HMO's internal appeal process and wish to have their appeal of a utilization management decision reviewed by an independent utilization review organization. Physicians and members who exercise the right to file a complaint or appeal may not be penalized by the HMO for exercising this right.

I recognize that consumer protections are largely dependent upon the ability of physicians to be advocates for their patients. I believe our HMO regulations support you in this very important role and I know I can count on your commitment that the needs of patients are always the most important consideration.

Sincerely,

Len Fishman
Commissioner

HMO Consumer Bill of Rights

1. The right to have access to a Primary Care Physician or his/her back-up 24 hours a day, 365 days a year for urgent care.

2. The right to call 911 in a potentially life-threatening situation without prior authorization from the member's Primary Care Physician or the HMO. For all other nonlife-threatening situations, members should contact their Primary Care Physician.

3. The right to have an HMO pay for a medical screening exam in an emergency room to determine whether an emergency medical condition exists. The HMO will pay for the cost of the medical screening even if it is determined by the HMO not to be an emergency.

4. The right to continue receiving medically necessary covered services from a provider who has been terminated by an HMO for up to 120 days. For members who are pregnant, the right to continued medically necessary covered services from a terminated provider extends to the postpartum evaluation of the member, up to six (6) weeks after delivery.

5. The right to have decisions denying or limiting services be made only by a physician. In addition, if the physician making the decision to deny or limit services is not the member's Primary Care Physician, such physician must directly communicate with the member's Primary Care Physician. If this is not possible, the Primary Care Physician must be supplied with the physician's name and a telephone number where he or she can be reached.

6. The right to receive from a participating provider, in terms that the member understands, an explanation of his/her complete medical condition, recommended treatment, risk (s) of the treatment, expected results and reasonable medical alternative, whether or not these are covered benefits.

7. The right to know how the HMO pays its doctors so that members will know if there are financial incentives or disincentives tied to medical decisions and to be provided with a telephone number and address to obtain additional information about compensation methods if desired.

8. The right to appeal a decision to deny or limit coverage, first within the HMO and then through an independent utilization review organization for a $25 filing fee. The fee can be waived in hardship cases.

9. The right to know that members and providers cannot be penalized for filing a complaint or appeal.

10. The right to obtain a current directory of participating providers.

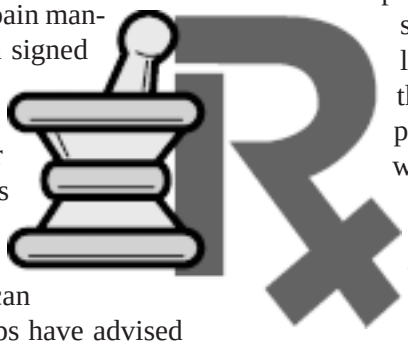
11. The right to have a choice of participating specialists within the network following authorization from a Primary Care Physician or HMO to see a participating specialist.

12. The right of members with chronic disabilities to be referred by their Primary Care Physician or HMO to specialists who are experienced in treating their disabilities.

Revisions To CDS Prescribing And Dispensing Regulations Adopted

New regulations have been adopted by the Board of Medical Examiners which streamline and consolidate all requirements for the prescription, administration and dispensing of drugs.

The most notable of these changes deal with the use of controlled dangerous substances for pain management. Recently, Governor Whitman signed legislation which called upon the Board of Medical Examiners to implement regulations to establish the standards for the prescribing of controlled substances in excess of the 120 dosage unit limitation, to achieve effective pain management. Representatives of the American Cancer Society and other interest groups have advised the Board that practitioners are often reluctant to provide medication to achieve effective pain management. Under the new rule, a physician who treats a patient suffering from pain from cancer, terminal illness, or chronic non-malignant conditions, which have been determined to be intractable or refractory to lesser treatment, may prescribe the dosage of Schedule II controlled dangerous substances necessary to achieve pain management. The regulations incorporate practice standards to assure that patients receiving any controlled dangerous substances are appropriately examined and adequately monitored. The medical record should properly document the need for such prescribing, and identify a treatment plan. The practitioner is expected to remain vigilant regarding the abuse potential of the medications prescribed.



Existing New Jersey law prohibits a physician from charging a fee for dispensed drugs in excess of 10% above their acquisition costs. The only exemption from this limitation are allergenic extracts and injectables, and drugs pursuant to an oncological or AIDS protocol. The law recognizes that the practice of pharmacy and the practice of medicine are two separate professions. The Board concurs and firmly believes that practitioners should not engage in the large-scale dispensation of drugs for profit. However, there are circumstances where the dispensing of medications, whether as a convenience to the patient in an emergency, or as an integral part of the patient's treatment, is appropriate. The new rule permits the practitioner to continue the dispensing role but with adequate safeguards to ensure that the practitioner remains objective. Physicians are also required to keep records of all dispensed drugs, with the exception of samples. Physicians may not charge when dispensing pharmaceutical samples. In addition, the seven-day supply limit does not apply to free samples.

According to the new regulations, practitioners are required to adhere to the strict control of medications and recordkeeping similar to those required of pharmacists. Drugs are to be kept in a safe, clean place, and practitioners must dispose of those drugs that become tainted or outdated.

The full text of the regulation follows. Licensees are encouraged to copy the text of the regulations and insert this into the Statute and Regulation Book which was distributed to all licensees last year.

Subchapter 7. Prescription, Administration And Dispensing Of Drugs

13:35-7.1 Definitions

The following words and terms, when used in this subchapter shall have the following meanings unless the context clearly indicates otherwise.

"Actual acquisition cost" means the cost actually incurred by the practitioner in acquiring a drug from a supplier and shall not include any amounts charged by any entity in which the practitioner has a direct or indirect financial or other beneficial interest.

"Administer" means the physical, in-person provision of a drug by way of injection, vaccine, allergenic extract or nebulized preparation or the provision of multiple dose vials of injectable medications.

"Amphetamine or sympathomimetic amine" means a drug which, chemically and pharmacologically, acts as a central nervous system stimulant.

"Anabolic steroid" means any drug or hormonal substance, chemically and pharmacologically related to testosterone (other than estrogen, progestin and corticosteroids), which promotes muscle growth, as well as any salt, ester, or isomer of such substance which acts in a similar manner in the human body.

"Controlled substance" means a drug classified in any of the schedules (I through V) of the Controlled Dangerous Substances Act, N.J.S.A. 24:21-5 to 24:21-8.1, recognized to have a potential for abuse or to lead to physical or psychological dependence.

"Dispensing" means the distribution of drugs intended by the physician for the personal use of the patient. "Dispensing" as used in this subchapter does not include the in-office administration of injections, vaccines, allergenic extracts or nebulized preparations or the provision of multiple dose vials of injectable medication.

"Drug" means any article recognized in the official United States Pharmacopoeia, official Homeopathic Pharmacopoeia of the United States or official National Formulary, or any supplement to those sources, including, but not limited to, a controlled substance, a prescription legend drug, an over-the-counter preparation, a vitamin or food supplement, or any compounded combination of any of the above or transdermal patch or strip, intended for use in the diagnosis, cure, mitigation, treatment or prevention of disease or medical condition in humans or intended to affect the structure or function of the human body. The term, as used in this subchapter, is synonymous with "medication" as used in N.J.S.A. 45:9-22.11. "Drug," as used in this subchapter, does not mean a device or durable medical equipment.

"Intractable pain" means pain which has been shown to be refractory or resistant to management with standard methods of treatment or for which insufficient relief has been found after reasonable efforts.

"Narcotic" means an analgesic drug which chemically and pharmacologically acts as an opioid.

"Practitioner" means any licensee subject to the regulatory authority of the Board authorized to prescribe or dispense drugs, including physicians, podiatrists and, to the extent permitted by law and rule, registered residents, resident permit holders, physician assistants and certified nurse midwives.

"Prescribing" means the act of directing that a patient take a drug included in prescription legend through either a written or verbal order.

"Terminal illness" means a diagnosed medical condition with a prognosis of less than one year.

13:35-7.2 Requirements for issuing written prescriptions for drugs

(a) A practitioner, acting within the scope of lawful practice and after an examination or evaluation of the patient's condition, may issue a written prescription for a drug to a patient, guardian or authorized representative in the form authorized by this section. The practitioner shall assure that appropriate follow-up is provided and that the effects of the drug are properly evaluated and integrated into the treatment plan for the patient.

(b) (Reserved)

(c) A practitioner shall include the following information on each written prescription:

1. The prescribing practitioner's full name, address, telephone number and proper academic degree or identification of professional practice for which licensed;

2. The full name, age and address of the patient;

3. The date of issuance;

4. The name, strength and quantity of the drug prescribed;

5. Words, in addition to numbers, to indicate the drug quantity authorized if the prescription is for a Schedule II controlled substance, for example: ten (10) Percodan; or five (5) Ritalin 5 mg;

6. The number of refills permitted or time limit for refills, or both;

7. The handwritten original signature of the prescribing practitioner;

8. An explicit indication, by initials placed next to "do not substitute" (see (e) below), if it is the prescribing practitioner's intention that a specified brand name drug be dispensed;

9. The prescribing practitioner's D.E.A. number, if the drug is a controlled substance; and

10. Adequate instruction for the patient as to frequency; a direction of "p.r.n." or "if needed" alone may be used if appropriate.

(d) A prescribing practitioner shall advise each patient by adequate notice, for example, by a sign or pamphlet in the waiting room of the office, that the patient may request the practitioner to substitute a generic drug for any brand name drug prescribed.

(e) Each practitioner shall use only written prescription blanks which shall be imprinted with the words "substitution permissible" and "do not substitute," with a space for the prescribing practitioner's initials next to the chosen option, and which shall not include preprinted information designed to discourage or prohibit substitution.

(f) When preprinted prescription blanks are not available, the full name of the prescribing practitioner must be legibly printed or stamped under the original signature.

13:35-7.3 Verbal prescriptions (Reserved)

13:35-7.4 Electronically transmitted prescriptions (Reserved)

13:35-7.5 Requirements for the dispensing of drugs and special limitations applicable to the dispensing of drugs for a fee

(a) A practitioner, acting within the scope of lawful practice and after an examination or evaluation of the patient's condition, may dispense a drug directly to a patient, guardian or authorized representative under the circumstances and limitations set forth in this section. The practitioner shall assure that appropriate follow-up is provided and that the effects of the drug are properly evaluated and integrated into the treatment plan for the patient.

(b) A practitioner who dispenses drugs in the office shall maintain those drugs in an area kept in an orderly and sanitary manner, and in accordance with standard pharmaceutical practice and manufacturer recommendations concerning storage conditions, including refrigeration, where necessary. A practitioner shall not maintain in inventory any drugs which are outdated, misbranded, deteriorated, adulterated, recalled, unlabeled, damaged, discontinued or which were previously dispensed to a patient. A practitioner shall be responsible for the disposal of such drugs in a manner which will not pose a health hazard and in accordance with all local, State and Federal requirements.

(c) All drugs dispensed shall be recorded in the applicable patient record.

(d) All drugs dispensed, with the exception of samples of drugs which are not controlled substances and which are packaged and labeled by the manufacturer, shall be recorded in a permanent, contemporaneous dispensing log which shall contain, at a minimum, the following:

1. The full name of the patient;

2. The complete name of each drug dispensed;

3. The strength and quantity of the drug dispensed;

4. Instructions as to the frequency of use;

5. The date of dispensing; and

6. The identity of the dispensing practitioner, if more than one practitioner dispenses in the office.

(e) Each different drug dispensed, in whatever dosage form, shall be placed in a separate container with

a safety closure cap, unless the patient requests otherwise or the drug is a pharmaceutical sample which has been packaged and labeled by the manufacturer.

(f) Each drug dispensed, including pharmaceutical samples, shall bear a legible label which includes the following:

1. The complete name of the drug dispensed;
2. The strength and quantity of the drug dispensed;
3. Instructions as to the frequency of use;
4. Special precautions, as appropriate; and
5. The expiration date of the drug.

(g) With respect to any drug which is not packaged by the manufacturer as a sample, the label shall also include the following:

1. The full name of the patient;
2. A list of the ingredients if the drug was compounded, not manufactured;
3. The date of dispensing; and
4. The identity of the dispensing practitioner.

(h) A practitioner shall not charge any patient a fee for a drug packaged and labeled by a manufacturer as a sample. For any drug dispensed which is not packaged by the manufacturer as a sample, a practitioner may charge a fee to allow for a recoupment of a portion of overhead and administrative costs, which fee shall not exceed the actual acquisition cost plus an additional sum not to exceed 10 percent of the actual acquisition cost.

(i) Subject to the exception in (j) below, if a practitioner charges a fee for the drug dispensed, either directly or through a global office visit charge which is more than that practitioner's usual and customary office visit charge, the practitioner:

1. Shall not dispense that drug or a substantially equivalent drug in a quantity or in dosages greater than that which would allow the patient a seven-day supply;
2. (Reserved)
3. Shall assure that information is given to the patient regarding the alternative availability of the drug outside of the practitioner's office; and
4. Shall disclose to the patient in advance of purchase and again on the bill the actual acquisition cost of the drug.

(j) In accordance with N.J.S.A. 45:9-22.11, the requirements set forth at (i) above shall not apply to a practitioner:

1. If the office at which the dispensing occurs is situated 10 or more miles from the nearest licensed pharmacy;
2. If the drug is dispensed pursuant to an oncological or AIDS protocol;
3. If the drug dispensed is a salve, ointment or drops; or
4. If the drug is dispensed in, and directly related to, the services rendered to the patient at:
   i. A hospital emergency room;
   ii. A student health center at an institution of higher education; or
   iii. A publicly subsidized community health center, family planning clinic or prenatal clinic.

13:35-7.6 Limitations on prescribing, administering or dispensing of controlled substances; special exceptions for management of pain

(a) When prescribing, dispensing or administering controlled substances, a practitioner shall ensure that a patient's medical history has been taken and physical examination accomplished, including an assessment of physical and psychological function, underlying or coexisting diseases or conditions, any history of substance abuse and the nature, frequency and severity of any pain. The medical record shall reflect:

1. A recognized medical indication for the use of the controlled substance;
2. The complete name of the controlled substance;
3. The dosage, strength and quantity of the controlled substance; and

4. The instructions as to frequency of use.

(b) With respect to Schedule II controlled substances, unless the requirements of (c) below are met, a practitioner shall not authorize a quantity calculated to exceed 120 dosage units or a 30-day supply, whichever is less.

(c) A practitioner may exceed the 120 dosage unit limitation for Schedule II controlled substances in (b) above, if the practitioner follows a treatment plan designed to achieve effective pain management which has been tailored to the needs of a patient who is suffering pain from cancer, intractable pain or terminal illness. The treatment plan shall state objectives by which treatment success is to be evaluated, such as pain relief and improved physical and psychological function, and shall indicate if any further diagnostic evaluations or other treatments are planned. The practitioner shall discuss the risks and benefits of the use of controlled substances with the patient, guardian or authorized representative.

(d) When controlled substances are continuously prescribed for management of pain for three months or more, the practitioner:

1. Shall review, at a minimum of every three months, the course of treatment, any new information about the etiology of the pain and the patient's progress toward treatment objectives;

2. Shall remain alert to problems associated with physical and psychological dependence; and

3. Shall periodically make reasonable efforts, unless clinically contraindicated, to either stop the use of the controlled substance, decrease the dosage, try other drugs such as nonsteroidal anti-inflammatories, or treatment modalities in an effort to reduce the potential for abuse or the development of physical or psychological dependence.

(e) If treatment objectives are not being met, the practitioner:

1. Shall assess the appropriateness of continued treatment with controlled substances or undertake a trial of other drugs or treatment modalities; and

2. Shall consider referring the patient for independent evaluation or treatment in order to achieve treatment objectives.

(f) A practitioner shall remain alert to the possibility that controlled substances may be misused or diverted. A practitioner managing pain in a patient with a history of substance abuse shall exercise extra care by way of monitoring, documentation and possible consultation with addiction medicine specialists, and should consider the use of an agreement between the practitioner and the patient concerning controlled substance use and consequences for misuse.

(g) The practitioner shall keep accurate and complete records including that information required by (a) above as well as:

1. The medical history and physical examination of the patient;

2. Other evaluations and consultations;

3. Treatment plan objectives;

4. Evidence of informed consent;

5. Treatments and drugs prescribed or provided, as in (a) above;

6. Any agreements with the patient; and

7. Periodic reviews conducted.

13:35-7.7 Prohibitions on prescribing, administering or dispensing of controlled substances for detoxification; limited exceptions

(a) A practitioner shall not issue a prescription for a narcotic drug listed in any schedule which drug is intended for the purpose of "detoxification" or "maintenance treatment."

(b) Unless registered with the New Jersey Department of Health and Senior Services to conduct a narcotic treatment program pursuant to N.J.S.A. 24:21- 10 and N.J.A.C. 8:65-11.2, a practitioner shall not dispense or administer a narcotic drug listed in any schedule which drug is intended for the purpose of "detoxification" or "maintenance treatment," except:

1. To relieve acute withdrawal symptoms, provided that:

i. Such treatment shall not exceed 72 hours;

ii. No more than one day's supply of the drug is provided to the patient at a time; and

iii. Arrangements are made for referring the patient to an addiction specialist or a drug treatment program for treatment; or

2. As an adjunct to other medical or surgical treatment for conditions other than addiction in a licensed health care facility.

13:35-7.8 Prohibitions and limitations in the prescribing, administering or dispensing of amphetamines and sympathomimetic amines

(a) A practitioner shall not prescribe, order, dispense, administer, sell or transfer any amphetamine or sympathomimetic amine designated as a Schedule II controlled substance for use in weight management, dieting or any other anorectic purpose, or for the treatment of fatigue.

(b) A practitioner may prescribe, dispense or administer amphetamine or sympathomimetic amine drugs or compounds designated as Schedule II controlled substances, only as follows:

1. For the treatment of the following conditions:

i. Narcolepsy established by recognized diagnostic criteria;

ii. Idiopathic Central Nervous System Hypersomnia established by recognized diagnostic criteria;

iii. Attention Deficit Disorder established by recognized diagnostic criteria;

iv. Drug-induced brain dysfunction;

v. Epilepsy;

vi. Depression shown to be refractory to other therapeutic modalities; and

vii. Senile apathetic behavior;

2. For immediate use in a hospital for acute conditions such as depression associated with illness or surgery;

3. For the differential diagnostic psychiatric evaluation of depression; or

4. For the clinical investigation of the effects of such drugs or compounds in which case, in addition to other requirements of applicable law, prior application therefor shall have been made to the Board and approval granted before any such investigation is begun.

(c) A practitioner who prescribes, dispenses or administers amphetamines or sympathomimetic amines shall prepare and maintain patient medical records which accurately reflect the utilization of any drug subject to this section, the specific diagnosis, the information upon which the diagnosis is based, including testing and consultations, and the treatment objectives for which the drug is being prescribed.

(d) The following list, although not exhaustive or exclusive, includes many of the generic and brand-name Schedule II drugs which are subject to this section:

Adderall

Amphetamine

Desoxyn

Dexedrine

Dextroamphetamine

Methamphetamine

Methylphenidate

Ritalin

13:35-7.9 Prohibitions and special limitations on prescribing, administering or dispensing anabolic steroids

(a) Unless an accepted medical necessity exists, a practitioner shall not prescribe, order, dispense, administer, sell or transfer any anabolic steroid or human growth hormone, for the purpose of hormonal manipulation intended to increase muscle mass, strength or weight. Body building, muscle enhancement, or increasing muscle bulk or strength through the use of anabolic steroid or human growth hormone by a person in good health for the intended purpose of improving performance in any form of exercise, sport or game is not a valid medical purpose.

(b) A practitioner shall prepare and maintain patient medical records which accurately reflect the utili-

zation of any substance or drug subject to this section, which records must indicate the diagnosis, the information upon which the diagnosis is based, and the purpose for which the substance or drug has been prescribed.

(c) The following list, although not exhaustive or exclusive, includes many of the generic and brand-name anabolic steroids and human growth hormones subject to this section:

Bolenone

Chlorotestosterone

(4-chlortestosterone)

Chorionic gonadotropin

Closebol

Dehydrochlormethyltestosterone

Dihydrotestosterone

(4-dihydrotesterone)

Ethylestrenol

Fluoxymesterone

Mesterolone

Methandienone

Methandriol

Methandrostenolone

Methenolone

Methyltestosterone

Mibolerone

Nandrolone

Norethandrolone

Oxandrolone

Oxymesterone

Oxymetholone

Somatrem

Somatropin

Stanolone

Stanozolol

Testolactone

Testosterone

Trebolone

13:35-7.10 Enforcement

(a) A violation of N.J.A.C. 13:35-7.1 through 7.9 may be deemed to constitute one or more of the following:

1. Distribution or dispensing of a controlled substance in an indiscriminate manner, or not in good faith, or without good cause, as prohibited by N.J.S.A. 45:1-13;

2. Gross or repeated malpractice, neglect, or incompetence in the practice of medicine, as prohibited by N.J.S.A. 45:1-21(c) and (d);

3. Professional misconduct, as prohibited by N.J.S.A. 45:1-21(e);

4. A failure to comply with the provisions of an Act or regulation administered by the Board, as prohibited by N.J.S.A. 45:1-21(h); and

5. Unprofessional conduct which would present an imminent danger to an individual patient or to the public health, safety or welfare, within the meaning of N.J.S.A. 45:9-19.5.

(b) A practitioner who is in possession of information which reasonably indicates that another practitioner has prescribed, dispensed or administered any drug or drugs in a manner which jeopardizes the public health, safety or welfare or for purposes deemed to be unlawful pursuant to this subchapter shall report such information to the Board pursuant to N.J.S.A. 45:9-19.5.

Sexual Misconduct : An Increasing Concern

Allegations of sexual impropriety and sexual misconduct by physicians and resulting prosecutions by the Attorney General before the Board, have increased in recent years. Matters involving sexual misconduct now comprise 20 percent of all serious public disciplinary actions. Sexual contact with a patient is considered to be a violation of the physician/patient relationship and deemed "professional misconduct" or "gross malpractice" under New Jersey law. In response to this increase, New Jersey became the first state in the nation to adopt comprehensive regulations and the third state in the nation to adopt guidelines for licensees of the Board of Medical Examiners. The regulations prohibit sexual contact between licensees and their patients and prohibits sexual harassment of coworkers, employees, and students as well as patients. The intent of the regulations is to protect the health, safety and welfare of New Jersey citizens by setting forth the parameters of proper professional conduct and requiring all licensees to adhere to a high standard of behavior. This will increase public confidence and trust in the profession and enhance the quality of care provided by licensees.

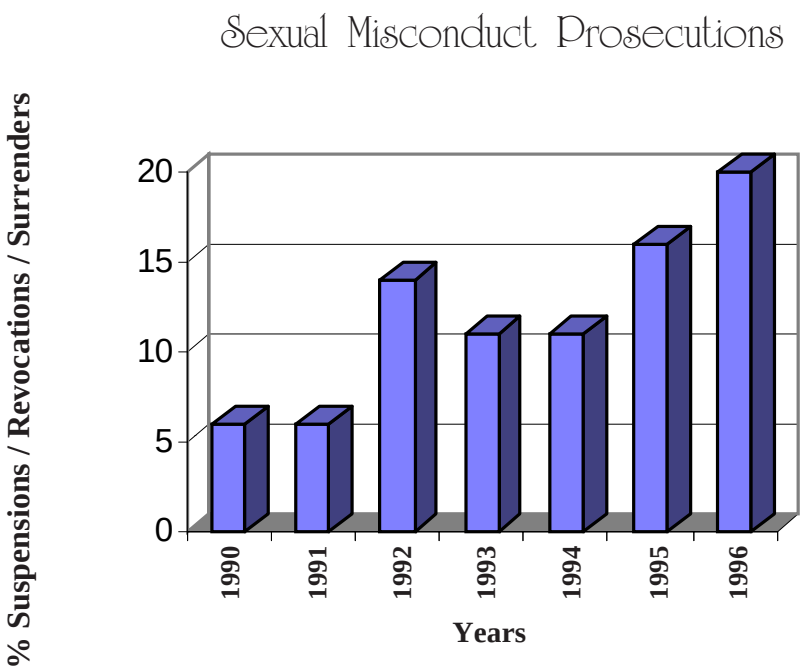
Under the regulations, sexual contact is banned between those in an ongoing physician-patient relationship. The relationship is considered ongoing unless previously terminated by a notice in writing or unless one year has elapsed since the last professional service was rendered to the patient. The Board believes that a formal termination of the physician-patient relationship is the minimum acceptable action necessary prior to engaging in a personal, intimate relationship.

Where psychiatric or psychotherapeutic care has been rendered, the physician-patient relationship is not considered terminated until at least two years following the last professional service, and the relationship is considered ongoing indefinitely if the patient remains vulnerable. The Board believes that it is particularly well established that additional protections are necessary when psychotherapeutic services are involved.

The rule includes an exemption which permits licensees to treat spouses or individuals with whom they are engaged in long-term committed relationships prior to the beginning of any treatment. The latter exemption is included in order to permit, for example, treatment of an individual with whom the licensee has resided for a lengthy period (in the absence of marriage) prior to the rendering of any medical care.

Licensees may not solicit sexual contact whether or not such contact is sought in exchange for professional services, nor may they engage in sexual harassment in any setting, professional or otherwise. Licensees are prohibited from engaging in gratuitous discussion of intimate sexual matters with patients, including self-disclosure by the physician regarding intimate sexual relationships. Activities (such as voyeurism and exhibitionism) which serve the physician or patient's prurient interest, sexual arousal or gratification or result in sexual abuse of either party are not permitted. Promoting, sanctioning or condoning sexual contact between group therapy participants is forbidden. Licensees are also required to provide sufficient physical privacy to patients during examination and treatment.

The Board also has adopted a policy statement regarding sexual activity between physicians and patients in the practice of medicine on January 11, 1995. This policy, is intended as an advisory to guide professional behavior and further expand upon the Board's reasoning in promulgating this rule.The full text (N.J.A.C. 13:35-6.3) of the regulation may be found on page 90 of the Statute and Regulation Books provided to all licensees in 1997.



Policy Statement Regarding Sexual Activity Between Physicians And Patients And In The Practice Of Medicine

It is beyond dispute that sexual contact with patients is in conflict with the very essence of the practice of medicine. Despite that fact, the Board of Medical Examiners continues to receive complaints of sexual activity involving physicians and other licensees with patients. While the Board is promulgating a regulation to specifically notify licensees of conduct which it deems to be violative of law and will subject them to disciplinary action, this statement is meant as an advisory to licensees to guide professional behavior and further expand upon the Board's reasoning in promulgating such a regulation.

A. Background. It is well established that sexual activity between physicians and patients is almost always harmful to the patient and is prohibited. Whether harkening back to the proscription of the Hippocratic oath[1], or referring to more recent pronouncements such as the Code of Medical Ethics of the Council of Ethical and Judicial Affairs of the American Medical Association which term sexual activities between physicians and patients harmful[2], commentators have uniformly condemned such activities by physicians.

(i) Rationale for the Policy. A patient must have absolute confidence and trust in his or her physician. Insertion of sexual activity into the professional relationship destroys such trust because the personal interest of the physician is in conflict with the interest of the patient.

(ii) Inequality of Power Between Physician and Patient. Physicians are in a unique position as to the physical and emotional vulnerability of patients. Physicians are expected to examine patients undressed who expose not only their bodies but the most intimate details of their personal lives.

(iii) Physician in Position of Authority. Patients seek assistance and guidance from physicians. The doctor/patient relationship is not one of equality, the patient being vulnerable to abuses of power.

(iv) Negative Psychological Consequences for Patient. Commentators and researchers have concluded that sexual activity between physicians and patients is almost always damaging to the patient.

(v) Public Trust in the Profession. In order to maintain the community perception of the integrity of the medical profession, personal boundaries must be maintained.

(vi) Sexual or Romantic Relationships with Former Patients. Sexual activity with a former patient may also be inappropriate if the patient has been unduly influenced by the prior professional relationship or if the physician utilizes trust, knowledge, or emotions derived from the previous professional relationship. The clearest example of this phenomenon is known as "transference" between a patient and psychotherapist, which may last for many years following the conclusion of therapy.

B. Recommendations and Guidelines for Conduct.

(i) Licensee Responsibility--The physician or other licensee is always responsible to ensure that the boundaries of the professional relationship are maintained. Licensees should therefore avoid verbal or physical behavior which might be interpreted as inviting a romantic or sexual relationship. Even if the patient encourages such behavior, it is the licensee's responsibility to maintain a professional manner.

(ii) Maintaining Boundaries in Psychotherapeutic Relationships--A licensee bears an even greater responsibility to establish and maintain boundaries between physician and patient in psychotherapeutic relationships. In furtherance of that obligation, a licensee should ensure that to the greatest extent possible, treatment should take place during the licensee's usual working hours in a professional setting, unless the specific therapy mandates otherwise (i.e. home visits for the housebound, in vivo desensitization as part of behavioral therapy). A licensee should not engage in economic dealings with psychotherapy patients.

(iii) Explanation of Procedures, Tests and Need for Examinations--This will ensure that patients do not misunderstand the appropriateness of the exposure of their bodies or the touching that occurs.

(iv) Patient Privacy--Examination conditions should ensure that patients are not embarrassed. To that end, licensees should provide privacy while a patient is removing or replacing undergarments and should provide examination gowns or draping cloths which limit exposure of the patient to the field of clinical interest.

(v) Chaperon--Consistent with promoting patient privacy, licensees should inform patients of the option of having a chaperon present during examination and should provide a chaperon when requested by a patient.

(vi) Avoidance of Discussion of Personal Matters--While it is appropriate for a licensee to discuss for example his or her training and qualifications with patients, in furtherance of the maintenance of appropriate boundaries, licensees should avoid any discussion of their own intimate personal problems or disclosure of details of their sexual lives.

[1] "... I will come for the benefit of the sick, remaining free ... of all mischief and in particular of sexual relations with both female and male persons ..."

[2] "sexual or romantic interactions between physicians and patients detract from the goals of the physician patient relationship, may exploit the vulnerability of the patient, may obscure the physician's objective judgment concerning the patient's health care, and ultimately may be detrimental to the patient's well being ... at a minimum, a physician's ethical duties include terminating the physician patient relationship before initiating a dating, romantic or sexual relationship with a patient . . . sexual or romantic relationships with former patients are unethical if the physician uses or exploits trust, knowledge, emotions or influence derived from the previous professional relationship."

Important Notice

Governor Signs New Malpractice Law

Governor Whitman recently signed legislation which requires that any physician or podiatrist who maintains a medical practice in the State of New Jersey, and has responsibility for patient care, be covered by medical malpractice liability insurance. If that coverage is not available, the physician or podiatrist will be required to obtain a letter of credit, in an amount to be established by the Board of Medical Examiners.

Although the statute took effect on March 17, 1998, it requires the Board of Medical Examiners to develop implementing regulations establishing the minimum amount of the line of credit. Regulations will also seek to clarify the circumstances under which a licensee will be deemed to be maintaining a practice and/or having responsibility for patient care. Once those regulations are adopted, licensees will be notified by direct mail of the specific requirements.

Physicians Cautioned On The Use Of Correct Names

The Administrative office of the Board of Medical Examiners seeks to caution physicians on the use of the name under which they have been issued a license. On a daily basis, consumers, hospitals, insurance companies and managed care plans ask the Board office to verify that the license is current and in good standing. If the inquirer references a name other than that under which the license is issued, the status cannot be verified. As a result, hospital or HMO privileges may be delayed or denied, or claims may not be paid.

Physicians may not practice using a name other than that used on the license documents. If it is necessary to change your name for reasons of marriage, divorce, or court order, such documentation must be submitted to the Board office so that new license documents and records can be created. These requests must be made in writing and the legal documents affecting the change must be included. A fee of $50.00 is charged for this service.

Change of Name/Address

Please print or type

Current Name: _____
First *Last* *Middle initial*

Former Name (if applicable): _____
First *Last* *Middle initial*

Address of record/mailing address: _____
Street address *City*

_____
City *State* *ZIP code* *Telephone number (include area code)*

Mail completed form to:
State Board of Medical Examiners
140E Front Street
Trenton, NJ 08608

Members of the State Board of Medical Examiners

1st Row: *Deborah Bradley; Janet Levick, M.D.; Gregory Rokosz, D.O.; Bernard Robins, M.D., President; Bennett Rothenberg, M.D., Treasurer; Arganey Lucas, M.D.; Christine Danser, C.N.M.; Sudhir Parikh, M.D.; Leah Ziskin, M.D.*
Back Row: *Kevin Earle, Executive Director; Kevin Walsh, P.A.-C.; Ricardo Fernandez, M.D.; Veronica Desmond; Glenn Farrell; James Ricketti, D.P.M.; Richard Rhee, M.D.; Gary Brickner, M.D.; Arthur Perry, M.D.; Donald Huston, D.O.; William Harrer, M.D., B.L.D.*

Not Present: *Daniel Weiss, Bassam Haddad, M.D., Robert Adair, M.D.*

LAPS New Jersey Department of Law & Public Safety

This newsletter was printed on recycled paper.

Division of CONSUMER AFFAIRS

NJ Department of Law and Public Safety
Division of Consumer Affairs
State Board of Medical Examiners
140 East Front Street
Trenton, N.J. 08608

BULK RATE
U.S. POSTAGE
PAID
TRENTON, N.J.
PERMIT #21